Department of Labor
National Life Building, Drawer 20
Montpelier, VT 05620-3401

SELF-INSURER'S REPORT

Calendar Year: _____

Company: _____

1. Total Workers' Compensation Benefits paid for the reporting period: _____

   (a) Indemnity: $ _____

   (b) Medical: $ _____

   (c) Other: $ _____

   (d) Total: $ _____

2. Assessment due [line (d) x .01]: $ _____

3. Claims for which benefits were paid for this reporting period. (this may be included on a separate form provided that all the information requested is present):

Name _____ Date of Injury _____ State File Number _____